

HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____

Date: _____

CURRENT COMPLAINTS:

- Headaches Neck Pain Arm Pain Arm/Hand Numbness Mid Back Pain Chest Pain Low Back Pain
 Buttock Pain Hip Pain Leg Pain Leg/Foot Numbness Other: _____

ONSET (How did your pain start?): Unknown Woke-up with it Bending Twisting Slip/Fall Accident

Explain: _____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

- | | | | | | |
|--|------------------------------------|---|--|---|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Murmur | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer – where? | | <input type="checkbox"/> Pass Out | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hemorrhoids |
| _____ | | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma |
| _____ | | <input type="checkbox"/> Other _____ | | | |
- Surgeries _____

FAMILY MEDICAL HISTORY:

Mother: Age: _____ Living Deceased
Father: Age: _____ Living Deceased
Siblings: Age: _____ Living Deceased

Please check each box with the appropriate letter if a family member has (had) the following problems (use M-Mother, F-Father, S-Sibling):

- | | | | | | |
|--|------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Murmur | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer – where? | | <input type="checkbox"/> Pass Out | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hemorrhoids |
| _____ | | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma |
| _____ | | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Allergies _____ | |
- Surgeries _____

CURRENT MEDICATIONS:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

() Tobacco () Type: _____ () Alcohol Type: _____
 () Year begun: _____ How often: _____
 () Still smoking How much: _____
 () Year quit: _____ How many years: _____
 () Packs per day: _____

() Exercise () None () light () Moderate () Heavy

Other: _____

REVIEW OF SYSTEMS: Do you have (had) the following?:

Check the appropriate box(s)

GENERAL: Weight gain Weight loss Fever Hair loss
 Weakness Other: _____

EYES: Eye strain Wear glasses or contact lenses Sensitivity to light

EAR, NOSE, THROAT Ringing in ears Hearing loss Discharge or pain Dizziness
 Runny nose Difficulty breathing through nose Sinusitis
 Painful teeth, gums, or palate Growths in the mouth
 Pain or difficulty swallowing Hoarseness

CARDIOVASCULAR Palpitations Chest pain Fainting Dizziness
 Varicose veins Difficulty climbing Stairs Pain in the legs
 Cold Feet/Hands Shortness of breath

RESPIRATORY Shortness of breath while walking Cough with or without phlegm
 Asthma/Wheezing Spit up blood
 Other: _____

GASTROINTESTINAL Abdominal pain Nausea Vomiting Diarrhea
 Hemorrhoids Change in shape or color of stool

GENITOURINARY Discharge Pain Frequent urination Pain with urination

MUSCULOSKELETAL Weakness Back Pain Neck Pain Leg Pain
 Arm Pain Shoulder Pain Numbness Headaches
 Other: _____

SKIN Jaundice Dry skin Pigment Change Growths
 Moles that have changed color, shape, or bleed

NEUROLOGIC Tremors Weakness Numbness Memory Loss
 Confusion Other: _____

Name: _____

Date: _____

File #: _____